Grievance System Reporting Guide

Version 3.0
September 22, 2007

Introduction:

The Grievance System Reporting Guide contains instructions on how to complete three separate reports for submission and review by the Division of Health Care Management (DHCM) as required by the applicable contract paragraph for Acute and ALTCS Contractors providing service to AHCCCS enrollees. The three reports are addressed in this order:

1. Claim Dispute Report
2. Authorization Request and Appeal Report
3. Enrollee Grievance Report

The instructions for completion are given in the paragraphs that follow and the formatting templates are also provided in attachments A, B, C, D & E.

Definition of Terms:

Action – The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of previously authorized services; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner as set forth in contract; the failure of a Contractor to act within the timeframes specified in contract; and for enrollees residing in a rural area with only one Contractor, the denial of an enrollee's right to obtain services outside the Contractor's network.

Appeal – A request for review of an action (other than those made on Provider Claim submissions) as "action" is defined in this policy.

Authorization Request (Standard) – A request for the authorization of services for which a Contractor must provide a decision as expeditiously as the member's health condition requires, but not later than fourteen (14) calendar days following the receipt of the authorization request with a possible extension of up to fourteen (14) calendar days if the member or provider requests an extension or if the Contractor justifies a need for additional information and the delay is in the member's best interest. (42 CFR 438.210)

Authorization Request (Expedited) – A request for the authorization of services which the provider or a Contractor determines that using the standard timeframe could seriously jeopardize the member's life or health or the ability to attain, maintain or regain maximum function. The Contractor must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires but no later than three (3) working days following the receipt of the authorization request, with a possible extension of up to fourteen (14) calendar days if the member or

provider requests an extension or if the Contractor justifies a need for additional information and the delay is in the enrollee's best interest. (42 CFR 438.210)

Claim Dispute – A dispute involving payment of a claim, the denial of a claim, the imposition of a sanction, or reinsurance.

Contractor – A Managed Care Organization (MCO) providing health care to acute or long term care enrollees.

Date of Decision (DOD) – For Authorization Requests the date that the Contractor makes and communicates the decision to the member and/or their designated representative.

Date of Processing (DOP) – Date that the appeal, claim or claim dispute decision is communicated by the Contractor.

Date of Receipt (DOR) – Date that the authorization request, appeal, claim or claim dispute is received by the Contractor.

Day – Calendar day unless otherwise specified.

Enrollee – A person eligible for AHCCCS and who is enrolled with a Contractor, also known as a member.

Notice of Action – The written notice to the member regarding an action by the Contractor. The contents of a Notice of Action are strictly defined in Contract and Policy.

Notice of Appeal Resolution - The written notice to the member and/or their designated representative regarding the final determination of an appealed action. The contents of a Notice of Appeal Resolution are strictly defined in Contract and Rule.

Notice of Decision – The written notice to the provider regarding the final determination of a disputed claim payment or claim denial. The contents of a Notice of Decision are strictly defined in Contract and Rule.

Overturned – The original decision of the Contractor is determined incorrect or incomplete and is reversed. This category is further divided into those disputes that are reversed due to Contractor error in processing (**overturned due to incorrect handling or secondary review**) and those that are reversed due to additional information being submitted by the member or provider in support of reversal (**overturned due to additional information submitted**).

Partially Overturned – The original decision of the Contractor was reversed, but the outcome is not entirely in the member and/or provider's favor. This category is further divided into those disputes that are reversed due to Contractor error in processing (**partially overturned due to incorrect handling or secondary review**) and those that are reversed due to additional information being submitted by the member or provider in support of reversal (**partially overturned due to additional information submitted**).

Turn Around Time (TAT) – The time from the date of receipt to the date of decision.

Upheld – The original determination of the Contractor is maintained.

Claim Dispute Report

General Instructions:

The Claim Dispute report should be completed using the guidelines below and the report must be submitted on the first day of the 2nd month following the month being reported to the address below:

Compliance Officer
AHCCCS Division of Health Care Management
701 E. Jefferson St. (MD 6500 for Acute, MD 6100 for ALTCS)
Phoenix, AZ 85034

1. The Contractor should generate and submit the report with an accompanying cover letter that summarizes the data; explains significant trending in either direction (positive or negative); any interventions applied to areas of concern; as well as any changes to categorical sub-classification that may have been implemented due to Contractor drill-down on a specific category of complaint.

2. Categorical sub-classifications for Claim Disputes are at the discretion of the Contractor based on its internal definitions, but must be clearly defined in an attached legend in the format of the Contractor's choosing. Suggested classifications are included in the instructions that follow.

Spreadsheet Instructions: (Spreadsheet is Attachment A)

A. Summary of Claim Disputes:

The numbers in Section A should be reported by age of the Claim Dispute as determined by Date of Receipt (DOR) through Date of Processing (DOP); and also by total number in the category.

A1. The number of Claim Disputes that remained open from the previous reporting period (reported in Row A4) should be carried over to this report.

A2. Total number of Claim Disputes logged as received during the reporting period.

A3. Total number of Claim Disputes closed during the reporting period.

A4. The total number of Claim Disputes remaining from the previous reporting period added to those received during the current period and subtracting those closed during the current period (A1 + A2 – A3 = A4).

B. Claim Dispute Decisions:

The numbers in Section B should be reported as a total number of disputes that can be assigned to the category.

B1. The total number of upheld Claim Disputes (excluding untimely dispute filings) during the current period including those that were opened in previous periods.

B2. The total number of Claim Disputes received by the Contractor later than twelve (12) months after the date of service, later than twelve (12)months after the date that eligibility is posted or later than sixty (60) days after the date of the denial of a timely claim submission.

B3. The total number of overturned Claim Disputes during the current period; including those received in previous periods.

- I. Overturned due to a secondary review finding that with all available information at the time of first review, the claim was inappropriately denied based on medical necessity or administrative criteria.
- II. Overturned due to additional information which was not available at the time of the initial review and may or may not have substantially affected the Contractor's ability to determine the appropriate action.

B4. The total number of partially overturned Claim Disputes during the current period, including those received in previous periods.

- I. Partially overturned due to a secondary review finding that with all available information at the time of first review, the claim was inappropriately denied based on medical necessity or administrative criteria.
- II. Partially overturned due to additional information which was not available at the time of the initial review and may or may not have substantially affected the Contractor's ability to determine the appropriate action.

B5. The total number of Claim Disputes requiring an extension.

B6. The total number of Claims forwarded for reprocessing as the result of an overturned, or partially overturned, Claim Dispute.

C. State Fair Hearing Statistics:

The numbers in Section C should be reported by the total number of Hearing Requests meeting the categorical criteria.

C1. The total number of requests for State Fair Hearing (RFH) received during the reporting period.

C2. The number of RFH that were forwarded to the AHCCCS Office of Administrative Legal Services (OALS) within five (5) business days of receipt by the Contractor.

C3. The number of RFH that were forwarded to the AHCCCS Office of Administrative Legal Services (OALS) more than five (5) business days from the date of Contractor receipt.

C4. The total number of cancelled (withdrawn or vacated) RFH.

I. Those cancelled (withdrawn or vacated) RFH that resulted from a settlement agreement initiated by the Contractor.

C5. The total number of Director's Decisions received during the reporting period that found in favor of the Provider, either in whole or in part.

C6. The total number of Director's Decisions received during the reporting period that found in favor of the Contractor's determination (; excluding Decisions reported in C4).

D. Categorical Trending Analysis:

The numbers in Section D should be reported as both a total number per category and as a percentage of the total number of disputes received for the reporting period.

D1-D5. List the top 5 categories of dispute by volume using the agreed upon acronym or abbreviation,

Available categories (not exclusive of new categories as needed and explained in a separate cover letter) include:

COD (Coding Dispute) – Disputes of a coding nature such as claims containing incorrect HCPCS; CPT; ICD-9 codes; Revenue Codes and/or modifiers.

DSI (Data Source Issues) – Disputes that are in reference to incorrect recognition of contract; provider registration or member enrollment status.

NPA (No Prior Authorization) – Instances where a claim was denied for requiring prior authorization.

NAM (No Authorization Match) – Instances where a claim was denied because the billed charges or length of stay do not correlate to the Contractor's prior authorization records.

CPE (Claim Processing Error) – Disputes that challenge the correctness of information presented on the Remittance Advice (Examples include: processed to incorrect provider, incorrect member, incorrect procedure code, etc...).

TOC (Timeliness of Claim) – Claims that are resubmitted as a challenge to the finding of timeliness of the original claim submission.

TOP (Timeliness of Payment) – Disputes that are filed on claims that have not been adjudicated.

NPC (Not Paid Correctly) – Dispute filed due to a difference in the expected reimbursement and the Contractor's remittance.

E. Provider Trending Analysis:

The numbers in Section E should be reported with both a total number per provider and the category with the largest number of disputes received from the provider in the reporting period.

E1-E5. List the top five (5) providers, by NPI or AHCCCS PIN number if no NPI is available, with the largest volume of claim disputes filed during the reporting period and the category of the largest percentage of disputes filed by that provider for the period (Example: Provider X; 145 Disputes; NPC).

Authorization Request and Appeal Report

General Instructions:

The Authorization Request and Appeal Report should be completed using the guidelines below and the report must be submitted on the first day of the 2nd month following the month being reported to the address below:

Compliance Officer
AHCCCS Division of Health Care Management
701 E. Jefferson St. (MD 6500 for Acute, MD 6100 for ALTCS)
Phoenix, AZ 85034

1. The Contractor should generate and submit the report with an accompanying cover letter that summarizes the data; explains significant trending in either direction (positive or negative); any interventions applied to areas of concern.

Spreadsheet Instructions: (Spreadsheet is Attachment B)

A. Summary of Authorization Requests:

A1. The total number of authorization requests received during the reporting period to contain all categories of prior authorization requests regardless of urgency or assigned priority (i.e. Standard, Expedited, Extended, etc.). ALTCS Program Contractors should recognize one Authorization Request for each Case Manager Assessment that occurs during the reporting period. This is inclusive of in-home, alternative residential setting and nursing facility member assessments.

A2. The number of authorization requests that were not approved as requested during the reporting period (denials, suspensions, reductions, terminations). Further subdivided into the following categories:

I. Not a Covered Benefit/Benefit Exhausted
II. Not Medically Necessary
III. Out of Network Provider
IV. Not Enough Information to Render a Decision within the legal timeframe
V. System/Program Issues, Including Coverage by Another Entity (BHS, CRSA, TPL)

A3. The percentage of authorization requests that resulted in an action: A2 divided by A1 x 100.

B. Type of Request: **IMPORTANT NOTE: The data in this section, and only the data in this section, is related to those cases received within the reporting period and completed prior to report submission.**

Section B contains a breakdown of the categories summarized in section A. The data in this section should be reported by the Total Number of Authorization Requests received during the reporting period, the Total Number of Authorization Requests Completed within Timeliness Standard and the Percentage of Authorization Requests Completed Timely (as calculated by dividing the timely completed requests by the total number of completed requests within the category).

B1. The number of standard authorizations as defined under the guidelines of this reporting guide.

B2. The number of standard authorization requests that were extended by fourteen (14) days due to member request or Contractor determination of necessity.

B3. The number of expedited authorization requests as defined under the guidelines of this reporting guide.

B4. The number of expedited authorization requests that were extended by fourteen (14) days due to member request or Contractor determination of necessity.

B5. The number of expedited authorization requests that were determined not to require expedited review based on medical necessity and were, therefore, handled under the standard process guidelines.

C., D. & E. Standard Appeals: This section contains information regarding Standard appeals of a Contractor's action as defined in this guide.

The data in Section C is reported by age of the standard appeal as determined by subtracting DOR from the last day of the reporting period and the total number of appeals that meet the criteria for standard appeals as defined in this guide.

C1. The number of standard appeals opened on the first (1^{st}) day of the current reporting period, as reported in line C5 of the previous period.

C2. The number of standard appeals received during the reporting period.

C3. The number of standard appeals closed during the reporting period.

C4. The number of standard appeals closed during the reporting period that were completed within thirty (30) days.

C5. The number of standard appeals remaining open on the last day of the current reporting period.

The data in Section D is reported as a total count of appeals closed during the reporting period that fall into each category.

D1. The total number of upheld standard appeals.

D2. The total number of standard appeals received by the Contractor later than sixty (60) days from the date of the Notice of Action.

D3. The total number of overturned standard appeals. This category is further divided as follows:

I. Overturned due to a secondary review finding that with all available information at the time of first review, the request was inappropriately denied based on medical necessity or administrative criteria.
II. Overturned due to additional information which was not available at the time of the initial review and may or may not have substantially affected the Contractor's ability to determine the appropriate action.

D4. The total number of partially overturned standard appeals.

I. Partially overturned due to a secondary review finding that with all available information at the time of first review, the request was inappropriately denied based on medical necessity or administrative criteria.
II. Partially overturned due to additional information which was not available at the time of the initial review and may or may not have substantially affected the Contractor's ability to determine the appropriate action.

D5. The total number of standard appeals requiring fourteen (14) day extensions to the thirty (30) day review period.

The data in Section E is to be reported as a total count of Member State Fair Hearing (RFH) files that meet the criteria listed below by category.

E1. The total number of RFH files received during the reporting period.

E2. The number of RFH that were forwarded to the AHCCCS Office of Administrative Legal Services (OALS) within the appropriate timeframe as dictated by the Arizona Administrative Code and the nature of the request (i.e. five (5) days for standard or same-day for expedited hearing requests).

E3. The number of RFH that were forwarded to the AHCCCS Office of Administrative Legal Services (OALS) outside of the appropriate timeframe as dictated by the Arizona Administrative Code and the nature of the request (i.e. five (5) days for standard or same-day for expedited hearing requests).

E4. The total number of cancelled (withdrawn or vacated) RFH.

I. Those cancelled (withdrawn or vacated) RFH that resulted from a settlement agreement initiated by the Contractor

E5. The total number of Director's Decisions received during the reporting period that found in favor of the Member either in whole or in part.

E6. The total number of Director's Decisions received during the reporting period that found in favor of the Contractor's determination (Excluding Decisions reported in E4).

F., G. & H. Expedited Appeals: This section contains information regarding requests for expedited review of an appeal of a Contractor's action as defined in this guide.

The data in Section F is reported by age of the appeal as determined by subtracting DOR from the last day of the reporting period and the total number of appeals that meet the criteria for expedited appeals as defined in this guide.

F1. The number of expedited appeals that remained open on the first (1st) day of the current reporting period, as reported in line F5 of the previous period.

F2. The number of expedited appeals that were received during the reporting period.

F3. The number of expedited appeals that were closed during the reporting period.

F4. The number of expedited appeals closed during the reporting period that were completed within three (3) days.

F5. The number of expedited appeals that remained open on the last day of the current reporting period.

The data in Section G is reported as a total count of appeals closed during the reporting period that fall into each category.

G1. The total number of upheld expedited appeals.

G2. The total number of expedited appeals received by the Contractor later than sixty (60) days from the date of the Notice of Action.

G3. The total number of overturned expedited appeals. This category is further divided as follows:

I. Overturned due to a secondary review finding that with all available information at the time of first review, the request was inappropriately denied based on medical necessity or administrative criteria.
II. Overturned due to additional information which was not available at the time of the initial review and may or may not have substantially affected the Contractor's ability to determine the appropriate action.

G4. The total number of partially overturned expedited appeals.

I. Partially overturned due to a secondary review finding that with all available information at the time of first review, the request was inappropriately denied based on medical necessity or administrative criteria.
II. Partially overturned due to additional information which was not available at the time of the initial review and may or may not have substantially affected the Contractor's ability to determine the appropriate action.

G5. The total number of expedited appeals requiring fourteen (14) day extensions to the three (3) day review period that were requested and/or granted by either party to the appeal.

G6. The total number of expedited appeal requests that did not meet the criteria for expedited review based on medical necessity and were, therefore, handled under the standard appeal process.

The data in Section H is to be reported as a total count of Expedited Member State Fair Hearing (RFH) files that meet the criteria listed below by category.

H1. The total number of RFH files received during the reporting period.

H2. The number of RFH that were forwarded to the AHCCCS Office of Administrative Legal Services (OALS) within the appropriate timeframe as dictated by the Arizona Administrative Code and the nature of the request (i.e. five (5) days for standard or same-day for expedited hearing requests).

H3. The number of RFH that were forwarded to the AHCCCS Office of Administrative Legal Services (OALS) outside of the appropriate timeframe as dictated by the Arizona Administrative Code and the nature of the request (i.e. five (5) days for standard or same-day for expedited hearing requests).

H4. The total number of cancelled (withdrawn or vacated) RFH.

I. Those cancelled (withdrawn or vacated) RFH that resulted from a settlement agreement initiated by the Contractor

H5. The total number of Director's Decisions received during the reporting period that found in favor of the member either in whole or in part (sustained or partially sustained).

H6. The total number of Director's Decisions received during the reporting period that found in favor of the Contractor's determination (excluding Decisions reported in H4).

Enrollee Grievance Report

General Instructions:

The Enrollee Grievance Report should be completed using the guidelines below and the report must be submitted on the first day of the 2nd month following the month being reported to the address below:

(Appropriate Compliance Officer)
AHCCCS Division of Health Care Management (DHCM)
701 E. Jefferson, MD 6500

1. A separate spreadsheet will be submitted for each of three (3) categories of grievance:

   Attachment C. Transportation
   Attachment D. Medical Service Provision
   Attachment E. Contractor/Program Contractor Service Level.

2. The Contractor should generate and submit the report with an accompanying cover letter that summarizes the data; explains trending in either direction (positive or negative); any interventions applied to areas of concern; as well as any changes to categorical sub-classification that may have been implemented due to Contractor drill-down on a specific category of complaint. Any delayed resolutions (those more than ninety (90) days from receipt) should be explained in this cover letter. The cover letter should also include the total number of cases received and closed due to transfer to Quality Management for review.

3. Categorical sub-classifications of Transportation, Medical Service Provision and Contractor/Program Contractor Service Level grievances are at the discretion of the Contractor based on executive reporting mechanisms but must be clearly defined in an attached legend in the format of the Contractor's choosing.

4. Any grievance process, or portion of the grievance process, that has been delegated to a Subcontractor through an approved arrangement, the Contractor will remain ultimately responsible for adhering to the reporting requirements contained within this guideline.

5. All questions regarding the reporting requirements should be directed to the Acute Care or ALTCS Compliance Officer assigned to the Contractor.

Spreadsheet Instructions: (Spreadsheet is Attachments C, D & E)

All figures reported on the spreadsheet should be as listed below:

A. Total Received: The total number of grievances related to each sub-classification during the month beginning on the first (1st) calendar day and ending on the last.

B. Total Resolved: The total number of grievances that were closed through verbal or written methods based on research and response during the month beginning on the first (1st) calendar day and ending on the last.

C. First Contact Resolution: Total number of grievances resolved at the time of receipt.

D. 1-10 Days: Total number of grievances resolved within ten (10) days of receipt.

E. 11-30 Days: The total number of grievances resolved in more than ten (10) days, but less than thirty one (31) days.

F. 31-60 Days: The total number of grievances resolved in more than thirty (30) days, but less than sixty one (61) days.

G. 61-90 Days: The total number of grievances that were either resolved more than sixty (60) days after receipt but in less than ninety one (91) days. *Subtracting the totals from each of the timeframe columns from the Total Resolved column will leave the reviewer with those grievances that were resolved more than one (1) quarter from receipt. Please address any delayed resolutions in the cover letter if necessary. Contractor non-compliance with the Enrollee Grievance Policy located in the AHCCCS Contractor Operations Manual (ACOM) for timely resolution of grievances may result in corrective action and escalation as defined in the Sanction paragraph of the applicable contract.

H. Average Time to Resolve (ATR): Sum of days to resolve each case individually divided by Column B.

I. Previous Month's ATR: Column H from report submitted for previous month.

J. Current Month from Previous Year ATR: Column H from report submitted for the coinciding month in the previous contract year.

K. (ROW) Summary Totals of each column: Please sum columns A-J appropriately at the bottom of each column as defined by row K.